

Guidance on Primary Spend for Health Insurers

Office of the Health Insurance Commissioner

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This memorandum is put forth by the Office of the Health Insurance Commissioner (OHIC) at the request of health insurers and after public consultation with key stakeholders and OHIC's Health Insurance Advisory Council (HIAC). It addresses how "primary care" should be defined for the purposes of planning for compliance with the primary care spend component of the OHIC Affordability Standards and for assessing compliance with the standard. The primary care spend component of OHIC's Affordability Standards states that health plans shall increase the proportion of their medical expenses spent on primary care by five percentage points from 2010 to 2014. This money should be an investment in improved capacity and care coordination, rather than a simple shift in fee schedules.¹

Factors Considered

In developing this guidance, OHIC sought to take the following factors into consideration:

1. The significant investment in primary care required of health plans under the Affordability Standards.
OHIC estimates that over the five years of the standard (2010 – 2014), an additional \$120 - \$196 million dollars will be invested in primary care in Rhode Island above baseline levels.
2. The need for demonstrated results.
System evaluation measures used to assess the efficacy of the Affordability Standards include overall commercial health insurance premium trend, inpatient readmissions per capita, preventable ER visits and admissions per capita and primary care physician staffing ratios and satisfaction.
3. The lack of certainty as to which investments will definitively result in the desired short term outcomes.
4. The varying levels of capacity (and interest) that currently exist in primary care practices to build the infrastructure required of patient-centered medical homes.
5. The significant salary gap that exists between primary care physicians and specialists and its likely effect on the future supply of primary care physicians.
6. The existing work and investments by health insurers to comply with the primary care spend standard in 2010.
7. The stated desire of most HIAC members to have primary care investments deliver meaningful results soon.
8. The existing resources, spending practices, financial incentives and capacity to invest within non-primary care components of the delivery system.

¹ The final standards are in response to comments received on the initial draft of January 2011. OHIC appreciates the thoughtful comments from numerous members of the community, which are posted [here](#), at www.ohic.ri.gov.

9. The frustration expressed by primary care clinicians with multiple programs to improve care management from multiple insurers which are often are not well coordinated and result in administrative burdens for clinicians.
10. The great dependency on the fee for service payment system, which encourages productivity at the expense of care coordination.
11. The concerns expressed by several public comments that Patient Centered Medical Home activities do not adequately address the needs of most pediatric patients and practices, which are marked by a high degree of office access and low chronicity.
12. Concerns expressed by several public comments that absent standards by public officials, health plans will continue to revert to fee for service payments rather than facilitate payment reform.

Guidance for Primary Care Spending

Given the factors considered, the following investments by health insurers fit within the definition of primary care for the purposes of the Affordability Standards:

1. Money spent by insurers in payments to primary care physicians and primary care practices.
Priorities are: fee-for-service payments, pay-for-performance incentives for documented improvements in population goals set by the affordability standards, payments for structural changes at the practice (e.g. electronic records, data reporting capacity from those electronic records), and payments for supplemental staff or supplemental activities not traditionally considered within the scope of primary care (e.g. patient educators, patient navigators and payments to other providers by the primary care physician).
2. Money spent by insurers for services provided by a third party integrated into the primary care setting - to either patients or the practice itself.
Priorities are practice training, nurse care managers, behavioral health and pharmacy co-location.
3. Money spent by insurers in support of multi-payor collaboration for primary care, including the All Payor Patient Centered Medical Home Project and its administration.
4. Money spend by insurers to promote early and comprehensive access to high quality primary care for children, consistent with CPT coding and newly developed children's preventive screening schedules, including:
 1. Afterhours telephone calls
 2. Email communication
 3. Provision of sick and well child care at the same office visit
 4. Developmental screening
 5. Vision screening
 6. Hearing screening

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7. Postpartum Depression screening
 8. Evening, weekend and holiday office hours
 9. Office used in an emergency
 10. Vaccine administration
 11. Care coordination
5. Money spent by insurers to build primary care workforce capacity, including support for loan forgiveness programs targeting new Rhode Island primary care physicians, nurse practitioners, physicians assistants and clinical social workers; and money spent for training and mentoring of those clinicians by primary care physicians.

To facilitate payment reform and practice transformation, the following expectations for each health insurer are set for the percentage of primary care payments which must be paid in the above categories in means other than fee for service payments, based on self reported data to OHIC:

2011:	25%
2012:	30%

Absent compelling evidence from a requesting health insurer, the following items are **not** considered primary care for the purposes of the Affordability Standards:

1. Money spent by insurers to non-primary care providers for services or activities outside the primary care setting, regardless of a primary care capacity building intent.
2. Money spent by insurers for health system capacity building outside the primary care practice, such as third party data reporting capacity.

Notes:

- The Beacon and CSI Patient Centered Medical Home Projects will lead to greater consensus, and consistency of investments and payment methodologies across health insurers.
- For non-primary care settings, sufficient financial capacity exists for realigning current investments to help build stronger primary care, if the financial incentives (payments, contractual terms and patient benefit designs) are put in place.

This guidance is subject to continual review and revision, based on what is learned as the health insurers and primary care physicians proceed and are held accountable for their investments and the results.